Annual Report

MoHealthNet for kids

Prepared by the Department of Social Services
for the
Missouri General Assembly

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Acknowledgement

This report contains research and analysis completed by Alicia Smith & Associates, LLC.

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Introduction and Scope of the Evaluation

This annual report on Missouri's program for heath care for uninsured children/State Children's Health Insurance Program (SCHIP) is being submitted to the General Assembly as required by Section 208.650 of the Revised Statutes of Missouri. The SCHIP program operated as part of a Medicaid Section 1115 Healthcare Demonstration Waiver program (1115 Waiver) between September 1, 1998 and September 30, 2007. The 1115 Waiver originally expanded eligibility to uninsured children, adults leaving welfare for work, uninsured custodial parents, uninsured non-custodial parents and uninsured women losing their Medicaid eligibility 60 days after the birth of their child.[1] Effective September 2007, Missouri's SCHIP program began operating as a combination SCHIP program. Missouri provides presumptive eligibility for children in families with income of 150% of the federal poverty level (FPL) or below until an eligibility decision is made. Uninsured children age birth through age 18 with family income below 150% of FPL are covered under the MO HealthNet expansion. Uninsured children under age 1 with family income more than 185% but less than 300% of FPL and uninsured children age 1 through age 18 with family income between 151% and 300% of FPL are covered under a Separate Child Health Program. Beginning September 2005, co-pays were eliminated in lieu of graduated premiums for all families with incomes greater than 150% of FPL**.** The SCHIP program has the following goals:

- Reduce the number of people in Missouri without health insurance coverage;
- Increase the number of Missouri children, youth and families who have medical insurance coverage; and
- Improve the health of Missouri's medically uninsured population.

Per the statute, this report focuses on three questions:

Study Question 1: What is the impact of the SCHIP program on providing a comprehensive array of community based wraparound services for Seriously Emotionally Disturbed Children (SED) and children affected by substance abuse?

Study Question 2: What are the overall effects of the SCHIP program? Specifically, what is:

- The number of children participating in each income category?
- The effect on the number of children covered by private insurers?
- The effect on medical facilities, particularly emergency rooms?
- The overall effect on the health care of Missouri residents?
- The overall cost to the state of Missouri?
- The methodology used to determine availability for the purpose of enrollment, as established by rule?

Study Question 3: Does the SCHIP program have any negative impact on the number of children covered by private insurance because of expanding health care coverage to children with a gross family income above 185% of the federal poverty level (FPL)?

[1] Service delivery to children began September 1, 1998. Service delivery for adults began February 1, 1999.

Throughout this report, we use the following terminology:

MO HealthNet or **Medicaid** refers to program for the Title XIX state plan Medicaid population.

SCHIP refers to the targeted low-income expansion program for children.

Data Sources and Approach

This report relied on the use of previously aggregated, readily available data from the state of Missouri and obtained from other sources. Major data sources are as follows:

- Health Status Indicator Rates – Department of Health and Senior Services (DHSS), Community Health Information Management and Epidemiology (CHIME);
- Missouri Information for Community Assessment (MICA) – DHSS;
- Monthly Management Report – Department of Social Services (DSS); and
- Multiple Data Requests – MO HealthNet Division (MHD), DSS and Department of Mental Health (DMH).

In addition to the aforementioned data sources journal articles and health publications produced by the federal government and national health policy researchers were utilized.

Study Question 1: *What is the impact of the SCHIP program on providing a comprehensive array of community based wraparound services for seriously emotionally disturbed (SED) children and children affected by substance abuse?*

Wraparound services are a class of treatment and support services provided to a SED child and/or the child's family with the intent of facilitating the child's functioning and transition towards a better mental health state. Wraparound services include family support services, case management, respite care, family assistance, targeted case management, transportation support, social and recreational support, basic needs support and clinical/medical support.

Important parameters to be considered are:

- Comparisons of utilization of wraparound services across service delivery systems are focused on evaluating whether managed care organization (MCO) enrollment impacts how and/or what wraparound services are provided. Eligibility and service utilization data from DMH and MHD for the evaluation period were compiled and analyzed.

- DMH and MHD have developed joint protocols and guidelines for the provision of wraparound services. DMH provides the funding for the services (either full funding or the state's match). DMH also coordinates and oversees the delivery of these services.

- The results from this year's report are not directly comparable with those reported last year because this evaluation is for a 15-month period rather than the 13-month period of last year's report. This 15-month period (from October 1, 2007 – December 31, 2008) was used to move to a calendar year reporting period (the reporting period had followed the waiver years). However, we did not want to exclude from the analysis the final three months of 2007 because data from these months were not included in the evaluation from last year. Moving forward, the analysis will be conducted for each calendar year.

Methodology for Data Analyses

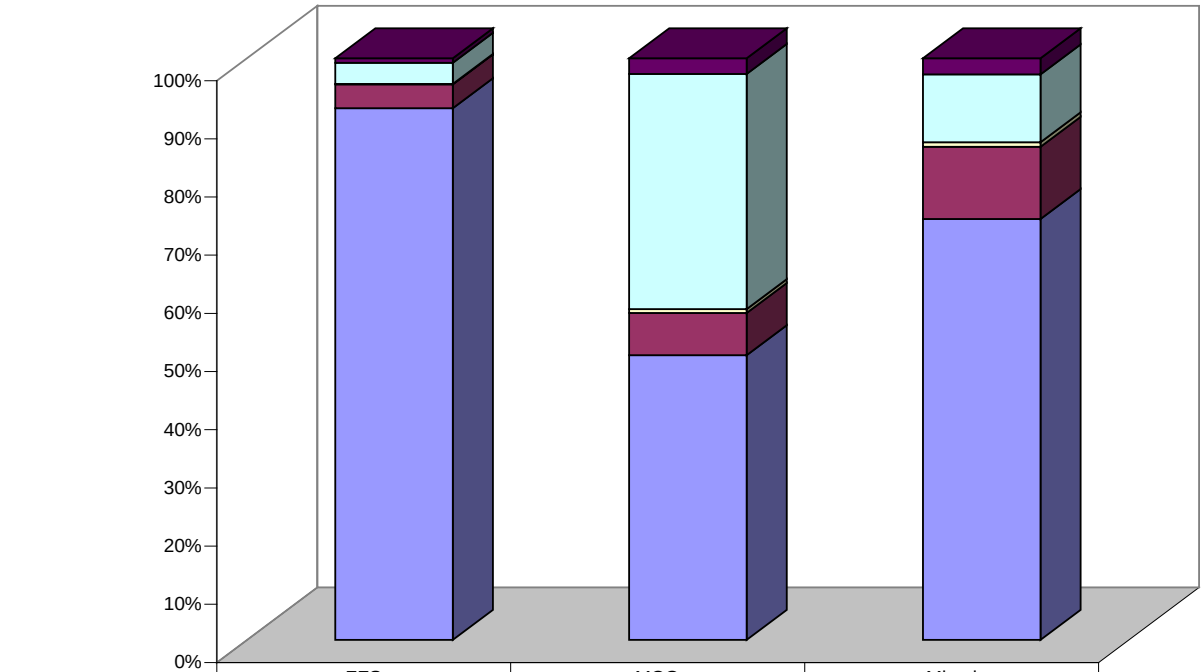
DSS and DMH data on SCHIP program eligibility, MCO enrollment and wraparound service utilization beginning October 1, 2007, and ending December 31, 2008, were used in this analysis. There were 1,641 children in the SCHIP program population who received wraparound services during the study period. For this analysis, the group was further divided into 889 fee-for-service (FFS) participants and 752 managed care organization (MCO) participants. Of the 752 MCO participants, 279 received services exclusively through MCOs and 473 received services through FFS and MCOs. The table on page 4 shows that the total units of all wraparound services per child for the FFS population was slightly greater than for the exclusively MCO population; the mixed MCO/FFS population had the greatest average number of units of services per child. The figure on page 4 shows how the mix of services differed among the populations. For example, case management services accounted for 91% of the services utilized by the FFS population, while amounting to 49% of the MCO population, and 72% of the mixed group. Conversely, respite services amount to just 4% of the FFS group, 40% of the MCO group and 12% of the mixed group.

SCHIP Children's Wraparound Service Utilization by Service

	Family Assistance	Family Support	Other Case Management	Respite	Targeted Case Management	Wrap-around Services	Grand Total
Quantity of Services							
FFS	717	16	8,311	636	7,703	140	17,523
MCO	371	33	1,528	2,070	978	138	5,118
Mixed	1,455	92	3,303	1,368	5,183	325	11,726
Services per Child							
FFS	0.8	0.0	9.3	0.7	8.7	0.2	19.7
MCO	1.3	0.1	5.5	7.4	3.5	0.5	18.3
Mixed	3.1	0.2	7.0	2.9	11.0	0.7	24.8

Source: Department of Social Services and Department of Mental Health

Share of Services by FFS, MCO, and Mixed FFS/MCO Participants



	FFS	MCO	Mixed
Wraparound services	0.8%	2.7%	2.8%
Respite	3.6%	40.4%	11.7%
Family Support	0.1%	0.6%	0.8%
Family Assistance	4.1%	7.2%	12.4%
Case Management	91.4%	49.0%	72.4%

Note: Case Management includes targeted case management and other case management. Respite includes independent and youth respite care. Bars represent 100 percent of service count for each category. Percentages may not add to 100 due to rounding.

These statistics alone are not conclusive evidence of a disparity, particularly without an analysis of the populations' differences, what non-wraparound mental health and substance abuse services the individuals are receiving, and whether there are differences unrelated to the service delivery model. For example, some services may be more easily obtained in an urban area where managed care exists (as demonstrated by the mixed group's utilization) than a rural area (where there is no managed care).

These data demonstrate that SCHIP children with SED are receiving certain wraparound services, particularly case management and family assistance services. However, it appears that, regardless of service delivery system, relatively few families are accessing family support or wraparound services.

Study Question 2: What are the overall effects of SCHIP program?

1. What is the number of children participating in the program in each income category?

For the most recent twelve-month period, July 2008 through June 2009, SCHIP program enrollment ranged from just under 60,000 participants to more than 66,000 participants (*See table, right*).

SCHIP Participants by Premium and Non-Premium

	Up to 150% FPL (non-premium)	Above 150% to 300% FPL (premium)	Total
Jul – 2008	39,692	19,790	59,482
Aug – 2008	41,433	20,235	61,668
Sep – 2008	41,465	20,846	62,311
Oct – 2008	42,341	21,058	63,399
Nov – 2008	42,303	21,522	63,825
Dec – 2008	42,806	21,872	64,678
Jan – 2009	43,073	21,892	64,965
Feb – 2009	43,526	22,172	65,698
Mar – 2009	43,934	22,666	66,600
Apr – 2009	42,346	21,069	63,415
May – 2009	42,676	21,825	64,501
Jun – 2009	42,916	22,217	65,133

Source: Department of Social Services, Monthly Management Reports

2. What is the effect of the SCHIP program on the number of children covered by private insurers?

Among those children who do have insurance, there has been redistribution over the past nine or so years by type of coverage both in Missouri and in the nation as a whole. As discussed in previous evaluations, there has been an overall decline in employer sponsored insurance (ESI). However, it is not evident that the SCHIP program has caused these reductions. Notably, the rate of ESI is dropping nationwide. There are several reasons for the decline in ESI:

- **A loss of jobs, particularly over the past several years** – in June 2007 the national unemployment rate was 4.5%; in June 2008 it was 5.5%; and in June 2009 it was 9.5%. Missouri's pattern is very similar with an increase from 5.0% in June 2007 to 5.8% in June 2008 and up to 9.3% in June 2009.[2]

- **A decrease in the percentage of jobs with benefits – 69% in 2000 to 63% in 2008.**[3] **[Data available mid-September from Kaiser/HRET survey.]** Declines in ESI coverage rates are often tied to:

  (1) Shifts in employment from large to small firms.

  (2) Shifts from industries more likely to provide ESI to industries less likely to provide ESI (high-coverage industries include mining, manufacturing, utilities, finance/insurance/real estate, education and public administration; low-coverage industries include agriculture, construction, transportation, wholesale/retail, trade, information/communication, professional health and social services and art/entertainment). Certainly in Missouri these changes have been occurring. For example, between January 2000 and June 2008, people working in jobs classified as manufacturing declined 29%. During that same time, the percent of people working in construction jobs increased 13%. Between 2008 and 2009, both industries lost jobs

[2] US Department of Labor, Bureau of Labor Statistics. *Regional and State Employment and Unemployment: June 2009*. US Department of Labor, Bureau of Labor Statistics. *Regional and State Employment and Unemployment: June 2008*. US Department of Labor, *Bureau of Labor Statistics. Regional and State Employment and Unemployment: June 2007.* Available on-line http://www.bls.gov/LAU/

[3] The Kaiser Family Foundation and Health Research and Educational Trust (HRET), "Employer Health Benefits 2008 Annual Survey," (2008), http://ehbs.kff.org/

although the decline was more precipitous for manufacturing (a 37% decrease) than for construction jobs (an 8.3% decrease). [4]

(3) Shifts from full-time to part-time work.

- **Increases in the cost of ESI to employers**. The cost of ESI has increased, particularly relative to increases in workers' earnings. As a percent of total premiums paid, the employee portion has remained relatively constant at 16% for single coverage and 27% for family coverage. However, in terms of dollar amounts the employee must pay, there have been large increases; between 2000 and 2008 premiums for single and family coverage more than doubled—an increase of more than 100 %—from $28 to $60 per month for single coverage and from $135 to $280 for family coverage.[2] **[Data available mid-September from Kaiser/HRET survey.]** During this same time real median income has decreased from $52,500 in 2000 to $50,303 in 2008 (2000 dollars are adjusted and reported in 2008 dollars). Notably, the decline in real income between 2007 ($52,163 in 2008 dollars) and 2008—3.6%—is the largest one-year decline since 1967.[5] This suggests that ESI, when offered, is becoming less affordable for many people, particularly those with lower incomes.

Study Question 3 (*see page 12*) provides additional information on the impact of the SCHIP program on the number of children covered by private insurance.

3. What is the effect of the SCHIP program on medical facilities, particularly emergency rooms?

It is well documented that uninsured individuals are more likely to be hospitalized for preventable conditions and use emergency rooms (ERs) to receive needed care.[6] Therefore, if the preventable hospitalizations and ER utilization rates for the SCHIP program population are similar to other insured populations and for MO HealthNet participants, we could infer that the program is having a positive effect on medical facilities and ERs (e.g., they have fewer avoidable admissions and there are fewer children using the ER when a visit to a physician might be more appropriate).

To answer this question the following indicators were examined:

- Frequency of preventable hospitalizations (hospitalizations are considered to be avoidable when the associated primary diagnosis is for a preventable or manageable illness); and,
- ER visits.[7]

Utilization of these services was compared across three populations:

- Children eligible for medical assistance through the SCHIP program;[8]
- Children otherwise eligible for medical assistance (MO HealthNet [Medicaid] children);[9] and,
- Children not eligible for any publicly funded medical assistance (Non-MO HealthNet children); which consists primarily of individuals with commercial, i.e., private health insurance.

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[4] US Department of Labor, Bureau of Labor Statistics. *Regional and State Employment and Unemployment: June 2009*. US Department of Labor, Bureau of Labor Statistics. *Regional and State Employment and Unemployment: June 2008*. US Department of Labor, *Bureau of Labor Statistics. Regional and State Employment and Unemployment: June 2007.* US Department of Labor, Bureau of Labor Statistics. *Regional and State Employment and Unemployment: June 2000*. Available on-line http://www.bls.gov/LAU/

[5] Shierholz, Heidi (September 10, 2009): *"New 2008 Poverty, Income Data Reveal Only Tip of the Recession Iceberg."* Washington, DC: Economic Policy Institute. Available at: http://www.epi.org

[6] Kaiser Commission on Medicaid and the Uninsured, "The Uninsured and Their Access to Health Care." October 2007.

[7] From "Missouri Monthly Vital Statistics", 29(4), 1995, State Center for Health Statistics, Missouri Dept. of Health. The diagnoses associated with avoidable hospitalizations in this study are: Angina; Asthma; Bacterial Pneumonia; Cellulites; Chronic Obstructive Pulmonary Disease; Congenital Syphilis; Congestive Heart Failure; Dehydration; Dental Conditions; Diabetes; Epilepsy; Failure to Thrive; Gastroenteritis; Hypertension; Hypoglycemia; Kidney or Urinary Infection; Nutritional Deficiencies; Pelvic Inflammatory Disease; Severe Ear, Nose or Throat infection; Tuberculosis.

[8] The SCHIP program group includes children with eligibility codes 71, 72, 73, 74, and 75.

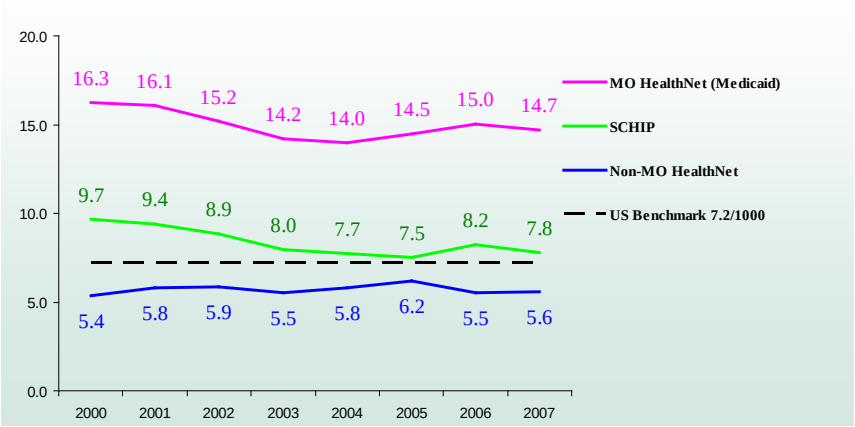
[9] The Medicaid group includes children with eligibility codes 06 to 70, 87, and 88. Note that this cohort includes children in foster care, the juvenile courts, group homes, and in the care of the Division of Youth Services. It also includes a relatively small number who are blind or have been determined to be disabled.

The American Academy of Pediatrics recommends the rate of hospitalizations for ambulatory-sensitive conditions (asthma, diabetes, gastroenteritis, etc.) as an indicator for evaluating the impact of SCHIP programs. High rates of preventable hospitalizations may indicate lack of access to or insufficient utilization of primary care services. Consistent with this premise, for calendar years 2000 through 2006, we examined rates of preventable hospitalizations, preventable hospitalizations due to asthma, ER visits and ER asthma visits. All rates are measured as the incidence per 1,000 population. DSS and DHSS data were used to compute these indicators.

Preventable Hospitalizations

- Since 2000, preventable hospitalizations for the SCHIP population have decreased by nearly 20%. During this time preventable hospitalizations for the MO HealthNet (Medicaid) population decreased nearly 10% while they increased by 4% for the non-MO HealthNet group.[10]

Preventable Hospitalizations Per 1,000 Missouri Children (All Diagnoses)



- By 2007, the SCHIP group rate of 7.8 was within 10% of the national benchmark of 7.2.

Preventable Asthma Hospitalization

- Since 2000, preventable hospitalizations due to asthma for the SCHIP population have decreased by slightly more than 33%. During this time preventable hospitalizations due to asthma for the MO HealthNet (Medicaid) population decreased by 27% and by more than 12% for the non-MO HealthNet population.

Preventable Asthma Hospitalizations Per 1,000 Missouri Children

- By 2007, the SCHIP population rate of 1.9 was nearly 20% below the national benchmark rate of 2.25.

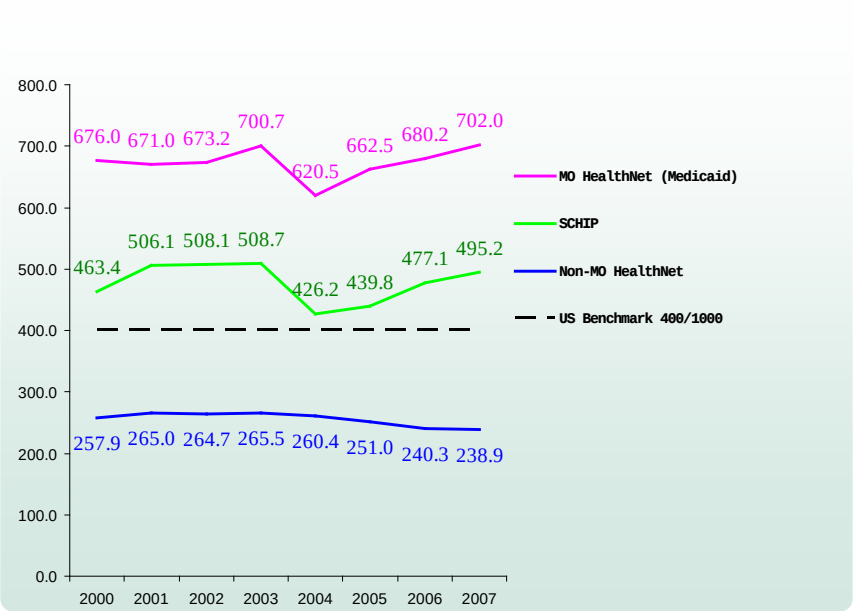
[10] Data in the figures may not compute to the summary percentages in the text due to rounding.

ER Visits

- Since 2000, ER visits for the SCHIP population have increased by 7%. During this time, ER visits for the MO HealthNet (Medicaid) population also increased--by just under 4% while ER visits for the non-MO HealthNet population decreased by more than 7%.

- By 2007, the SCHIP population rate of 495.2 was within 25% of the national benchmark rate of 400.

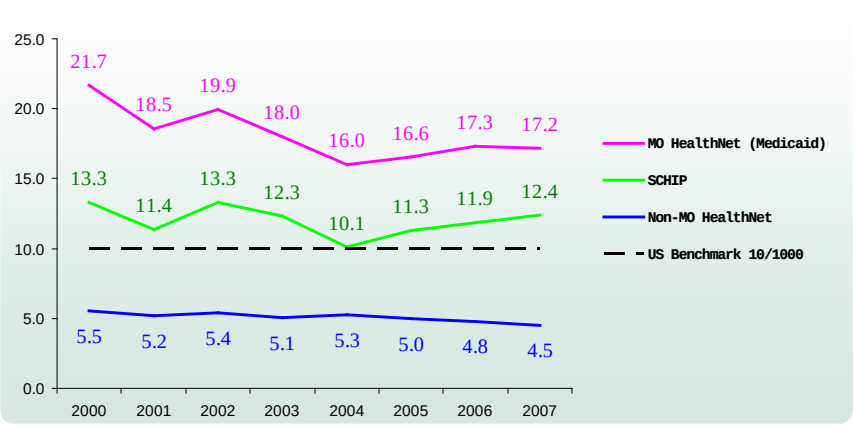
Preventable ER Visits Per 1,000 Missouri Children



Asthma ER Visits

- Since 2000, ER visits due to asthma decreased by almost 7% for the SCHIP population. ER visits decreased by more than 20% for the MO HealthNet (Medicaid) population and by nearly 19% for the non-MO HealthNet population.

Preventable Asthma ER Visits Per 1,000 Missouri Children



- By 2007, the SCHIP population rate of 12.4 was within 24% of the national benchmark of 10.

A summary of the indicators discussed is presented in the following table. Detailed data are included as Appendix I.

Summary of 2007 Indicators for Missouri Children under 19

	CHIP	MO HealthNet (Medicaid)	Non – MO HealthNet (non-Medicaid)	Benchmark
Preventable hospitalizations	7.8	14.7	5.6	7.2
Preventable asthma hospitalizations	1.9	3.4	0.9	2.25
ER visits	495.2	702.0	238.9	400.0
ER asthma visits	12.4	17.2	4.5	10.0

Data sources: Department of Health and Senior Services; Benchmark: Kozak , Hall and Owings (preventable hospitalizations); Health People 2000 (preventable asthma hospitalizations); CDC's Health, United States, 2005 (ER visits); CDC, NCHS Health E-Stats (ER asthma visits)

4. What is the overall effect of the SCHIP program on the health care of Missouri residents?

The SCHIP population is about 1% of the entire state population. The ability of this population to affect health care outcomes of Missourians as a whole would be difficult to discern. What we do know is that 6.8% of Missouri's children are uninsured, which ranks us 19th in the nation.[11] Without the SCHIP program approximately 65,000 additional children would most likely be uninsured, raising the state's percentage of uninsured children to 11.4% and lowering our rank to 42nd.

It is important for children to have health insurance. Below are just a few examples of what it means to a child to have health insurance coverage when compared to children without health insurance:[12]

- Insured children are six times more likely to have a usual site of care.
- Insured children are twice as likely to see a physician during the year.
- Insured children are six times more likely to receive medical care.
- Insured children are four times more likely to receive preventive dental care.
- Insured children are three times more likely to receive prescriptions.
- Insured children are more than twice as likely to receive treatment for recurring ear infections.
- Insured children with special health needs are three times more likely to get needed care.
- Insured children are nine times less likely to be hospitalized for a preventable problem.

5. What is the overall cost of the SCHIP program to Missouri?

The SCHIP program is funded with state (general revenue), federal and other dollars.[13] Actual expenditures for FY 2009 are provided below.

SCHIP Expenditures

	FY 2009 Actual
State (General Revenue)	$25,662,414
Federal	$96,276,427
Other	$7,566,332
Total	$129,505,173

11 U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplements, Table HIO-5. Health Insurance Coverage Status and Type of Coverage by State and Age for All People: 2008, available at: http://www.census.gov/hhes/www/cpstables/032009/health/h05_000.htm.
12 Kaiser Commission – Children's Health – Why Health Insurance Matters, May 2002.
13 Pharmacy Rebates Fund, Federal Reimbursement Allowance Fund, Pharmacy Reimbursement Allowance Fund, Health Initiatives Fund, Premium Fund and Medicaid Managed Care Organization Reimbursement Allowance Fund were available in FY 2009.

6. What is the methodology used to determine availability for the purpose of enrollment, as established by rule?

13 CSR 70-4.080, State Children's Health Insurance Program, sections (2), (3), (5), (6) and (11) is the rule that establishes the methodology to determine availability for enrollment.

Eligibility provisions for families with gross income of more than 150% of FPL:

- Children must not have health insurance for the six months prior to the application.
- If health insurance was dropped within the six months prior to application, prospective participants must wait six months after coverage was dropped to be eligible. Children with special health care needs who do not have access to affordable employer-subsidized health care insurance are exempt from the six month penalty for loss of insurance coverage without good cause and the 30-day waiting period for children in families with income of more than 225% of FPL, as long as the child meets all other qualifications for eligibility.
- Parents\guardians of uninsured children must certify the child does not have access to affordable health care insurance.

In addition to these provisions, the following rules apply to premium payments:

- Children in families with gross incomes of more than 150% but less than 225% of FPL are eligible once a premium has been received.
- Children in families with gross incomes of more than 225% and up to 300% of FPL are eligible 30 calendar days after the receipt of the application if the premium has been received.
- Total aggregate premiums can not exceed 5% of the family's gross income for a 12-month period.
- Premiums must be paid prior to delivery of service.

How are premiums set?	
Income Category	**Monthly Premium Calculation**
(1) More than 150% and up to and including 185% FPL	Amount is equal to 4% of monthly income between 150% and 185% of FPL for the family size.
(2) More than 185% and up to and including 225% FPL	Amount is equal to 8% of the monthly income between 185% and 225%of the FPL for the family size plus premium calculated in category 1.
(3) More than 225% and up to 300% FPL	Amount is equal 14% of the monthly income between 225% and 300% of FPL for the family size plus the premium calculated in categories 1 and 2.

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Study Question 3: Does the SCHIP program have any negative impact on the number of children covered by private insurance as a result of expanding health care coverage to children with a gross family income above 185% of the federal poverty level (FPL)?

This question is directed at the issue of crowd out, defined as a shift from private health insurance coverage to public coverage. This generally occurs in one of three ways:

- An individual drops private coverage for public coverage; or
- An enrollee with public coverage refuses an offer of private coverage (does not *take-up* the coverage); or
- Employers take actions they would not have taken in the absence of public coverage which have the effect of forcing or encouraging their employees to drop private coverage and shift to public coverage (for example, they increase premium contributions or no longer offer coverage at all).[14]

Crowd out does not occur when people, who would otherwise have become uninsured, enroll in a public program.[15]

Measuring Crowd Out

The existence and extent of crowd out could be determined by analyzing the mix of private and public coverage before and after a public program expansion. If all else is equal, a decrease in enrollment in private insurance occurring in the same timeframe as an increase in public coverage is evidence of crowd out. However, not all things are equal. As discussed in Study Question 2, Part 2, over the last several years there has been a shift from jobs that traditionally offered health coverage (i.e., manufacturing) to jobs not offering coverage (i.e., construction) and decreases in the percentage of firms offering employer-sponsored insurance (ESI) and increases in the cost of ESI. In addition, there has been a more than doubling of the unemployment rate: from 4.5 % in June 2007 to 9.5% in June 2009.

For crowd out to occur employers must take actions to steer employees away from ESI coverage and towards public coverage. This is difficult to determine because employers are experiencing annual increases in their costs related to providing health insurance and might increase employee contributions and/or stop providing coverage regardless of the existence of expanded public programs.

Employees contribute to crowd out by choosing not to take up the ESI coverage because enrolling in a publicly funded program will save them money. Again, determining what motivates people to act in certain ways is not easy. For example, employees may not take up dependent coverage because of increasing premiums and the existence of an expanded public program does not necessarily play into their decision.

Because of the inherent challenges in quantifying crowd out, the importance of the issue to policymakers, last year's debate in the United States Congress regarding the reauthorization of SCHIP, and ongoing health reform activities much research has been done in this area. Still there is no consensus on the prevalence of crowd out. For example:

- A 2004 synthesis, compiled by the Robert Wood Johnson Foundation, summarized the findings of 25 different models developed to measure the effects of crowd out. The crowd out estimates from these models ranged from no evidence of crowd out to upwards of 75% (not all of the findings were statistically significant).[16] The huge range in these estimates is due to differences in

[14] Davidson, G., L. A. Blewett, & K. T. Call (June 2004). *Public Program crowd-out of private coverage: What are the issues?* The Robert Wood Johnson Foundation: Research Synthesis Report No. 5.
[15] Davidson, Blewett & Call (June 2004).
[16] Davidson, Blewett & Call (June 2004).

the data (for example, the way it is collected); different assumptions in developing the model (for example, assumptions about how changes in the economy would affect private coverage); differences in the programs which have been studied (e.g., state differences or differences in income thresholds) and the inherent challenges in ascertaining the motivations of both employers and employees.

- In 2007, the Congressional Budget Office (CBO) estimated that among children there would be a reduction in private coverage of between a quarter and half of the increase in public coverage. Or, stated another way, for every 100 children who enroll in SCHIP programs, there is a reduction of between 25 and 50 children who have private coverage.[17] It is worth noting, however, that in its estimates CBO defines crowd out to include all children who are uninsured when they enroll but whose families would—in the absence of SCHIP or Medicaid—have purchased private coverage for their children in the future; CBO has not counted just those children who had private insurance that was dropped for public program coverage.[18]

- Finally, and most recently, the United States Government Accountability Office (GAO) examined the Centers for Medicare & Medicaid Services' (CMS) and states' efforts to minimize crowd-out to determine whether this is an area of concern.[19] They concluded in their February 2009 report to Congress that the data being collected is of limited use in assessing the extent to which crowd-out is a concern. In other words, there is not enough information to conclude that crowd-out is occurring at all and there certainly is not enough evidence to conclude that it is occurring at a rate high enough to warrant concern on the part of state and federal policy makers. As part of their repot GAO did recommend that CMS act to "ensure that states (1) collect and report consistent information on the extent to which SCHIP applicants have private insurance available to them and (2) take appropriate steps to determine whether available private health insurance is affordable for SHCIP applicants."

State Level Reports on Crowd Out

In addition to the general research on crowd out, CMS evaluations of crowd out in 16 states have found that:

- 8 states reported no evidence of crowd out;
- 5 states reported crowd out rates of less than five percent; and
- 3 states reported crowd out rates between 10 and 20 percent.[20]

The Congressionally mandated SCHIP Evaluation of experiences in ten states determined that although 28 percent of new entrants had ESI in the six months prior to enrollment:

- 14 percent involuntarily lost coverage
- 8 percent found the employer coverage unaffordable; and
- Only 6 percent voluntarily dropped their ESI.[21]

In Missouri, previous CMS-required evaluations on the SCHIP program have concluded that, though there were potential indicators – the increase in SCHIP program enrollment numbers concurrent with decreases in the current population survey reported private enrollment numbers – there was not enough

[17] Congress of the United States, Congressional Budget Office, "The State Children's Health Insurance Program," May 2007.
[18] Ku, L. (September 27, 2007). "Crowd-Out is Not the Same as Voluntarily Dropping Private Health Insurance for Public Program Coverage," Center on Budget and Policy Priorities.
[19] United States Government Accountability Office, "Report to the Chairman, Committee on Finance, U.S. Senate: State Children's Health Insurance Program; CMS Should Improve Efforts to Assess whether SCHIP Is Substituting for Private Insurance." February 2009.
[20] Dubay, Lisa. (August 29, 2007). "Crowd-Out Under SCHIP: Looking Back and Moving Forward." Power Point Presentation Available at: http://www.allhealth.org/briefing_detail.asp?bi=112
[21] Ibid.

evidence to support a conclusion that crowd out was occurring. That is, most likely, the changes in enrollment were due to economic conditions such as a reduction in the number of jobs that provide health insurance and increased cost shifting of health insurance premiums by employers to employees.[22]

For the evaluation period of September 1, 2003, through August 31, 2004, the authors of the Missouri evaluation spoke with 18 employers who provided general information about their companies and anecdotal information about their health insurance plans. In addition, two representatives of Chambers of Commerce were consulted about what they hear from their members regarding health insurance offerings and take up rates among employees.[23] Specifically these individuals were asked:

- Whether they consider the existence of public coverage, in particular expanded public programs, in deciding whether to offer ESI and in developing their offerings;
- How many employees take up individual and dependent coverage; and,
- If they were aware of any employees who opted out of dependent coverage because they were aware of the MO HealthNet [Medicaid] program and were going to enroll their children in it.

No employers indicated they considered the existence of public programs, in particular the existence of the SCHIP program, in developing their ESI offerings; rather, the employers cited cost as the primary reason for changing their ESI offerings. Regarding take up rates of ESI and, in particular, take up rates for dependent coverage, many of the employers who were consulted said there were no noticeable changes over the last several years; several others said that none of their employees has children or that their children are covered under a spouse's ESI plan. When asked, specifically, whether they had heard of, or were aware of, employees who did not purchase ESI for their children because they planned to enroll their children in MO HealthNet (Medicaid) (including the SCHIP program), seven employers and one Chamber of Commerce representative said, *yes*. However, the occurrence was uncommon – usually three to five of more than 100 employees per year. Two of these seven employers said that they have had employees return to them after declining coverage because the state had strongly encouraged them to take the ESI and not rely on the SCHIP program.[24]

While these anecdotes suggested there might have been some crowd out, there were other factors playing into these decisions. For example, a couple of employers suggested that some of these employees might have declined coverage even in the absence of the SCHIP program because they could not afford the premiums. In this scenario, these children would likely have become uninsured. Another employer indicated that due to their 90-day waiting period and high turnover rates (100%) many employees never become eligible for ESI. There is no crowd out in this scenario because the employees did not select the SCHIP program in lieu of ESI, rather, as with above, in the absence of the SCHIP program their children would likely be uninsured.

Summary and Conclusions

Given the inconclusive nature of all research done in the area of crowd out and the paucity of available and useful data (as indicated in the GAO report) it is impossible to state with certainty that crowd out is occurring. It is important to note that the General Assembly's action to extend premium and affordability requirements to a greater portion of the Missouri's SCHIP population has provided strong mechanisms to address crowd out.

[22] Alicia Smith & Associates, LLC. (2005). "Evaluation of the Missouri Section 1115 Waiver."
[23] Ibid
[24] Ibid

Appendix I

Hospitalization and ER Utilization Rates by Payer/Program (2000-2007)
Review period: October 1, 2007 - December 31, 2008
Data source: Missouri Department of Health and Senior Services (DHSS)

		Rate				
	MO HealthNet Region:	*Eastern*	*Central*	*Western*	*Other*	***State***
	Cal. Year:					
Asthma hospitalizations age <19	2000 SCHIP	5.2	1.8	3.9	1.7	**2.8**
Benchmark = 2.25/1,000 pop.	2001 SCHIP	3.0	1.8	2.3	1.3	**2.1**
Healthy People 2000	2002 SCHIP	2.5	1.8	2.9	1.2	**1.9**
Ref. footnote in report.	2003 SCHIP	2.9	1.3	2.7	1.6	**2.1**
	2004 SCHIP	2.9	1.2	1.6	1.2	**1.8**
	2005 SCHIP	2.6	0.8	1.6	1.0	**1.6**
	2006 SCHIP	2.3	1.0	2.3	0.9	**1.6**
	2007 SCHIP	3.5	0.7	1.9	0.8	**1.9**
	Change from 2000 to 2007	**-33.0%**	**-60.9%**	**-51.2%**	**-52.2%**	**-33.2%**
	2000 Non-MO HealthNet	1.3	0.9	1.1	0.9	**1.1**
	2001 Non-MO HealthNet	1.1	0.7	1.0	0.7	**0.9**
	2002 Non-MO HealthNet	1.2	0.8	0.8	0.8	**1.0**
	2003 Non-MO HealthNet	1.1	0.8	1.0	0.7	**0.9**
	2004 Non-MO HealthNet	1.3	1.1	0.8	0.8	**1.0**
	2005 Non-MO HealthNet	1.3	0.6	1.0	0.8	**1.0**
	2006 Non-MO HealthNet	1.2	0.8	0.9	0.7	**1.0**
	2007 Non-MO HealthNet	1.2	0.6	0.9	0.7	**0.9**
	Change from 2000 to 2007	**-9.4%**	**-30.6%**	**-17.8%**	**-17.3%**	**-12.4%**
	2000 MO HealthNet	7.6	3.4	4.5	2.6	**4.6**
	2001 MO HealthNet	4.9	2.9	3.2	2.9	**3.6**
	2002 MO HealthNet	5.3	3.2	3.6	3.0	**3.9**
	2003 MO HealthNet	5.3	2.7	3.1	2.8	**3.7**
	2004 MO HealthNet	5.0	2.3	2.5	2.7	**3.4**
	2005 MO HealthNet	4.6	2.6	3.0	2.1	**3.2**
	2006 MO HealthNet	5.0	3.1	3.0	2.3	**3.4**
	2007 MO HealthNet	5.0	2.3	2.9	2.5	**3.4**
	Change from 2000 to 2007	**-34.5%**	**-32.7%**	**-35.6%**	**-5.1%**	**-26.9%**
Asthma ER visits age <19	2000 SCHIP	24.7	9.0	19.5	7.1	**13.3**
Benchmark = 10/1,000 pop.	2001 SCHIP	17.7	5.1	13.5	7.8	**11.4**
CDC NCHS Health E-Stats	2002 SCHIP	19.5	11.5	17.4	8.2	**13.3**
Ref. footnote in report.	2003 SCHIP	18.4	6.6	17.5	8.3	**12.3**
	2004 SCHIP	15.7	5.6	12.0	6.5	**10.1**
	2005 SCHIP	18.5	6.8	11.8	7.1	**11.3**
	2006 SCHIP	19.9	8.1	13.7	6.3	**11.9**
	2007 SCHIP	20.8	5.4	16.0	6.2	**12.4**
	Change from 2000 to 2007	**-15.9%**	**-39.7%**	**-17.8%**	**-12.7%**	**-6.8%**
	2000 Non-MO HealthNet	7.6	3.0	6.1	3.3	**5.5**
	2001 Non-MO HealthNet	6.6	3.0	6.0	3.3	**5.2**
	2002 Non-MO HealthNet	6.9	2.9	6.1	3.3	**5.4**
	2003 Non-MO HealthNet	6.6	2.8	5.5	3.2	**5.1**
	2004 Non-MO HealthNet	6.9	3.2	5.1	3.5	**5.3**
	2005 Non-MO HealthNet	6.8	3.1	4.8	2.8	**5.0**
	2006 Non-MO HealthNet	6.2	3.1	4.9	3.1	**4.8**
	2007 Non-MO HealthNet	5.7	2.5	5.0	3.1	**4.5**
	Change from 2000 to 2007	**-24.8%**	**-16.4%**	**-17.8%**	**-4.8%**	**-18.6%**
	2000 MO HealthNet	36.2	13.2	26.2	10.0	**21.7**
	2001 MO HealthNet	28.1	10.7	22.8	9.7	**18.5**
	2002 MO HealthNet	31.0	11.9	22.9	10.6	**19.9**
	2003 MO HealthNet	28.0	11.6	20.2	13.4	**18.0**
	2004 MO HealthNet	25.0	9.9	17.6	8.9	**16.0**
	2005 MO HealthNet	26.5	11.1	17.8	8.8	**16.6**
	2006 MO HealthNet	30.1	11.2	17.1	8.2	**17.3**
	2007 MO HealthNet	28.1	11.2	18.7	8.6	**17.2**
	Change from 2000 to 2007	**-22.3%**	**-15.0%**	**-28.6%**	**-14.3%**	**-20.6%**

APPENDIX I (continued):
Hospitalization and ER Utilization Rates by Payer/Program (2000-2007)
Review period: October 1, 2007 - December 31, 2008
Data source: Missouri Department of Health and Senior Services (DHSS)

		Rate				
	MO HealthNet Region:	*Eastern*	*Central*	*Western*	*Other*	***State***
	Cal. Year:					
ER visits age <19	2000 SCHIP	367.6	393.4	388.4	546.3	**463.4**
Benchmark = 400/1,000 pop.	2001 SCHIP	490.1	497.3	471.6	531.9	**506.1**
Health, United States, 2005. CDC	2002 SCHIP	525.9	496.8	467.8	517.9	**508.1**
Ref. footnote in report.	2003 SCHIP	511.0	521.9	465.8	590.0	**508.7**
	2004 SCHIP	403.2	467.2	381.3	453.2	**426.2**
	2005 SCHIP	436.3	467.8	390.7	459.8	**439.8**
	2006 SCHIP	478.9	528.9	421.4	490.7	**477.1**
	2007 SCHIP	517.3	516.3	467.8	487.5	**495.2**
	Change from 2000 to 2007	**40.7%**	**31.2%**	**20.5%**	**-10.8%**	**6.9%**
	2000 Non-MO HealthNet	262.1	218.6	269.9	256.6	**257.9**
	2001 Non-MO HealthNet	256.6	244.9	296.3	259.9	**265.0**
	2002 Non-MO HealthNet	263.4	251.4	284.4	255.6	**264.7**
	2003 Non-MO HealthNet	265.3	253.1	281.8	256.9	**265.5**
	2004 Non-MO HealthNet	244.6	271.4	268.5	274.2	**260.4**
	2005 Non-MO HealthNet	243.9	442.7	248.1	258.4	**251.0**
	2006 Non-MO HealthNet	231.1	252.4	238.7	251.5	**240.3**
	2007 Non-MO HealthNet	232.5	236.2	233.4	253.5	**238.9**
	Change from 2000 to 2007	**-11.3%**	**8.1%**	**-13.5%**	**-1.2%**	**-7.4%**
	2000 MO HealthNet	713.6	681.7	637.0	656.8	**676.0**
	2001 MO HealthNet	642.4	704.4	628.4	709.9	**671.0**
	2002 MO HealthNet	674.9	710.0	581.7	708.6	**673.2**
	2003 MO HealthNet	691.3	754.9	618.1	737.8	**700.7**
	2004 MO HealthNet	596.3	700.9	557.1	654.1	**620.5**
	2005 MO HealthNet	602.1	765.1	570.7	688.0	**662.5**
	2006 MO HealthNet	696.9	547.5	575.4	697.4	**680.2**
	2007 MO HealthNet	709.8	769.4	623.6	719.6	**702.0**
	Change from 2000 to 2007	**-0.5%**	**12.9%**	**-2.1%**	**9.6%**	**3.8%**
Preventable hospitalizations age <19	2000 SCHIP	10.5	8.0	9.5	9.8	**9.7**
Benchmark = 7.2/1,000 pop.	2001 SCHIP	9.9	8.8	6.7	10.5	**9.4**
Kozak, Hall and Owings.	2002 SCHIP	6.8	9.2	8.9	10.0	**8.9**
Ref. footnote in report.	2003 SCHIP	6.7	6.6	8.2	9.9	**8.0**
	2004 SCHIP	7.0	7.0	6.9	8.8	**7.7**
	2005 SCHIP	7.5	6.4	6.2	8.4	**7.5**
	2006 SCHIP	8.2	8.1	6.3	9.2	**8.2**
	2007 SCHIP	8.7	6.3	7.7	7.7	**7.8**
	Change from 2000 to 2007	**-17.4%**	**-21.0%**	**-19.0%**	**-21.2%**	**-19.5%**
	2000 Non-MO HealthNet	5.5	4.9	4.9	5.7	**5.4**
	2001 Non-MO HealthNet	6.0	5.6	5.0	6.1	**5.8**
	2002 Non-MO HealthNet	5.9	6.4	5.1	6.2	**5.9**
	2003 Non-MO HealthNet	5.7	6.1	4.7	5.8	**5.5**
	2004 Non-MO HealthNet	6.1	6.3	4.7	6.2	**5.8**
	2005 Non-MO HealthNet	6.5	7.0	4.9	6.5	**6.2**
	2006 Non-MO HealthNet	5.9	5.8	4.5	5.9	**5.5**
	2007 Non-MO HealthNet	5.9	5.2	4.6	5.0	**5.6**
	Change from 2000 to 2007	**6.3%**	**5.5%**	**-5.6%**	**-12.2%**	**4.0%**
	2000 MO HealthNet	17.8	15.0	13.5	16.6	**16.3**
	2001 MO HealthNet	14.9	15.0	12.1	19.3	**16.1**
	2002 MO HealthNet	13.7	14.8	12.0	18.2	**15.2**
	2003 MO HealthNet	13.5	13.7	10.4	16.8	**14.2**
	2004 MO HealthNet	12.8	12.5	10.6	16.1	**14.0**
	2005 MO HealthNet	13.3	14.5	11.3	17.0	**14.5**
	2006 MO HealthNet	14.3	14.7	11.3	17.7	**15.0**
	2007 MO HealthNet	14.3	13.6	11.1	17.1	**14.7**
	Change from 2000 to 2006	**-19.7%**	**-9.2%**	**-17.8%**	**3.1%**	**-9.6%**

APPENDIX II:

DMH-DSS Wrap-Around Service Codes and Titles

Review period: October 1, 2007 - December 31, 2008

Wrap-Around Services (for children with SED and those affected by Substance Abuse)		
02500H	FAMILY SUPPORT	SED WA
20000H	CASE MNGMT-BACHELOR IND	SED WA
20001H	CASE MNGMT-PARAPROFESS IND	SED WA
20003H	CASE MNGMT-PHYSICIAN IND	SED WA
20004H	CASE MNGMT-LIC QMHP IND	SED WA
20005H	CASE MNGMT-LIC PSYCH IND	SED WA
20006H	CASE MNGMT-AD PR NURSE IND	SED WA
20008H	CASE MGMT-CHILD PSYCHITRST	SED WA
39601W	WRAP-AROUND SRVCS-YOUTH IND	SED WA
39603W	WRAP-AROUND SRVCS ADULT AS	SED WA
440001	RESPITE CARE - IND	SED WA
44001H	RESPITE SRVCS	SED WA
440021	RESPITE CARE YOUTH	SED WA
49004H	CHILD/ADOLES FAMILY ASSIST	SED WA
Y3127K	TARGET CASE MGMT (TCM) YTH	SED WA
Y3128K	TARGET CASE MGMT (TCM) YTH	SED WA

SED WA = SED Wrap-Around Service